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EXAMINER	
HARLE, JENNIFER I	

ART UNIT	PAPER NUMBER
3627	

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Please find below and/or attached an Office communication concerning this application or proceeding.

Office Action Summary	Application No. 10/088,795	Applicant(s) MARTIN ET AL.
	Examiner Jennifer I. Harle	Art Unit 3726

-- The MAILING DATE of this communication appears on the cover sheet with the correspondence address --

Period for Reply

A SHORTENED STATUTORY PERIOD FOR REPLY IS SET TO EXPIRE 3 MONTH(S) FROM THE MAILING DATE OF THIS COMMUNICATION.

- Extensions of time may be available under the provisions of 37 CFR 1.136(a). In no event, however, may a reply be timely filed after SIX (6) MONTHS from the mailing date of this communication.
- If the period for reply specified above is less than thirty (30) days, a reply within the statutory minimum of thirty (30) days will be considered timely.
- If NO period for reply is specified above, the maximum statutory period will apply and will expire SIX (6) MONTHS from the mailing date of this communication.
- Failure to reply within the set or extended period for reply will, by statute, cause the application to become ABANDONED (35 U.S.C. § 133).
- Any reply received by the Office later than three months after the mailing date of this communication, even if timely filed, may reduce any earned patent term adjustment. See 37 CFR 1.704(b).

Status

1)☒ Responsive to communication(s) filed on *22 March 2002* .

2a)☐ This action is **FINAL**. 2b)☒ This action is non-final.

3)☐ Since this application is in condition for allowance except for formal matters, prosecution as to the merits is closed in accordance with the practice under *Ex parte Quayle*, 1935 C.D. 11, 453 O.G. 213.

Disposition of Claims

4)☒ Claim(s) *1-6,8-15 and 17-21* is/are pending in the application.

4a) Of the above claim(s) _____ is/are withdrawn from consideration.

5)☐ Claim(s) _____ is/are allowed.

6)☒ Claim(s) *1-6,8-15 and 17-21* is/are rejected.

7)☐ Claim(s) _____ is/are objected to.

8)☐ Claim(s) _____ are subject to restriction and/or election requirement.

Application Papers

9)☐ The specification is objected to by the Examiner.

10)☐ The drawing(s) filed on _____ is/are: a)☐ accepted or b)☐ objected to by the Examiner.

Applicant may not request that any objection to the drawing(s) be held in abeyance. See 37 CFR 1.85(a).

11)☐ The proposed drawing correction filed on _____ is: a)☐ approved b)☐ disapproved by the Examiner.

If approved, corrected drawings are required in reply to this Office action.

12)☐ The oath or declaration is objected to by the Examiner.

Priority under 35 U.S.C. §§ 119 and 120

13)☐ Acknowledgment is made of a claim for foreign priority under 35 U.S.C. § 119(a)-(d) or (f).

a)☐ All b)☐ Some * c)☐ None of:

1.☐ Certified copies of the priority documents have been received.

2.☐ Certified copies of the priority documents have been received in Application No. _____ .

3.☐ Copies of the certified copies of the priority documents have been received in this National Stage application from the International Bureau (PCT Rule 17.2(a)).

* See the attached detailed Office action for a list of the certified copies not received.

14)☐ Acknowledgment is made of a claim for domestic priority under 35 U.S.C. § 119(e) (to a provisional application).

a) ☐ The translation of the foreign language provisional application has been received.

15)☒ Acknowledgment is made of a claim for domestic priority under 35 U.S.C. §§ 120 and/or 121.

Attachment(s)

1) ☒ Notice of References Cited (PTO-892)
2) ☐ Notice of Draftsperson's Patent Drawing Review (PTO-948)
3) ☐ Information Disclosure Statement(s) (PTO-1449) Paper No(s) _____ .
4) ☐ Interview Summary (PTO-413) Paper No(s). _____ .
5) ☐ Notice of Informal Patent Application (PTO-152)
6) ☐ Other: .

DETAILED ACTION

Claims 1-6, 8-15 and 17-21 are pending. Claims 1-6, 8-15 and 17-21 are rejected.

Examiner's Interpretation of Claim Terminology

The examiner has interpreted a central clearinghouse to include the administrators of health care plans, particularly managed care plans such as HMO's and certain PPO's. The specification defines a central clearinghouse as administering the financial aspects of the system. Specification, pg. 5. While it is noted that Applicant states that it is an objective of the invention to "provide a system for the payment of professional services that is not an insurance product," and to "provide a system for the payment of professional services outside of the current insurance system," applicant's claims define an insurance system and provide no differentiation. Specification, pg. 4. Applicant's Specification states that "in general the central clearinghouse contracts with professional service providers to provide professional services to consumers under the system, where the clearinghouse and providers agree on terms for the provision of services by providers to consumers, including the type of services to be provided the quantity of services to be provided, they payment to from clearinghouse, and the payment from consumers to providers."[1] Additionally, the Specification notes that the plan can be continuously evolving with additional services being added to the plan by doctors, monthly fees by patients being changed etc.[2] Thus, the central clearinghouse does more than just oversee the financial aspects of the system (i.e. that is where the money goes and the tracking of subscriber service providers and service receivers). It manages the affairs of the system by contracting and negotiating with the service provider to provide specific services at a specific fee and later renegotiating to add or

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[1] Specification, Detailed Description of the Preferred Embodiments, pg. 5, lines 25-30.

delete services or service providers; by selling services and then contracting with the consumer to provide the services, and collecting fees from the consumer and paying the service provider. The examiner further notes that she is not utilizing the HMO to define the actual place where the services are rendered but in a general sense to show that the components, i.e. the service provider, the service receiver, and the clearinghouse all exist as parts of an HMO. Moreover, it appears that applicant is actually defining prepaid health care, i.e. a HMO, where subscribers receive health care in exchange for the payment of a fixed, periodic- usually monthly-fee with some form of capitation.[3]

After careful review of the specification and prosecution history, the Examiner is unaware of any desire—either expressly or implicitly—by Applicant(s) to be their own lexicographer and to define a claim term to have a meaning other than its ordinary and accustom meaning. Therefore, the Examiner starts with the presumption that all claim limitations are given their ordinary and accustom meaning. See *Bell Atlantic Network Services Inc. v. Covad Communications Group Inc.*, 262 F.3d 1258, 1268, 59 USPQ2d 1865, 1870 (Fed. Cir. 2001)("[T]here is a heavy presumption in favor of the ordinary meaning of claim language as understood by one of ordinary skill in the art."); *CCS Fitness Inc. v. Brunswick Corp.*, 288 F.3d 1359,1366, 62 USPQ2d 1658, 1662 (Fed. Cir. 2002) (There is a "heavy presumption that a claim term carries its ordinary and customary meaning."). See also MPEP §2111.01 and *In re Zletz*, 893 F.2d 319, 321, 13 USPQ2d 1320, 1322 (Fed. Cir. 1989).[4]

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[2] Id. at pg. 8, lines 5-9.
[3] Harriett E. Jones and Dani L. Long, Principles of Insurance: Life, Health, and Annuities, Second Edition, Chapter 22: Managed Care, 1999, pp. 410-411.
[4] It is the Examiner's position that "plain meaning" and "ordinary and accustom meaning" are synonymous. See e.g. *Rexnord Corp. v. Laitram Corp.*, 274 F.3d 1336, 1342, 60 USPQ2d 1851, 1854 (Fed. Cir. 2001) ("[A]ll terms in a patent claim are to be given their plain, ordinary and accustomed meaning . . .").

In accordance with the ordinary and accustom meaning presumption, during examination the claims are interpreted with their "broadest reasonable interpretation . . . ." *In re Morris*, 127 F.3d 1048, 1054, 44 USPQ2d 1023, 1027 (Fed. Cir. 1997).[5]

However, if Applicant(s) wish to use lexicography and desire a claim limitation to have a meaning other than its ordinary and accustom meaning, the Examiner respectfully requests Applicant(s) in their next response to expressly indicate[6] the claim limitation at issue[7] and to show where in the specification or prosecution history the limitation is defined. Such definitions must be clearly stated in the specification or file history. *Bell Atlantic*, 262 F.3d at 1268, 59 USPQ2d at 1870, ("[I]n redefining the meaning of particular claim terms away from the ordinary meaning, the intrinsic evidence must 'clearly set forth' or 'clearly redefine' a claim term so as to put one reasonably skilled in the art on notice that the patentee intended to so redefine the claim term").[8] The Examiner cautions that no new matter is allowed.

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[5] See also MPEP §2111; *In re Graves*, 69 F.3d 1147, 1152, 36 USPQ2d 1697, 1701 (Fed. Cir. 1995); *In re Etter*, 756 F.2d 852, 858, 225 USPQ 1, 5 (Fed. Cir. 1985) (en banc).

[6] "Absent an *express intent* to impart a novel meaning, terms in a claim are to be given their ordinary and accustomed meaning. [Emphasis added.]" *Wenger Manufacturing Inc. v. Coating Mach. Sys.*, Inc., 239 F.3d 1225, 1232, 57 USPQ2d 1679, 1684 (Fed. Cir. 2001) (citations and quotations omitted). "In the absence of an *express intent* to impart a novel meaning to claim terms, an inventor's claim terms take on their ordinary meaning. We indulge a heavy presumption that a claim term carries its ordinary and customary meaning. [Emphasis added.]" *Teleflex Inc. v. Ficosa North America Corp.*, 299 F.3d 1313, 1325, 63 USPQ2d 1374, 1380 (Fed. Cir. 2002) (citations and quotations omitted).

[7] "In order to overcome this heavy presumption in favor of the ordinary meaning of claim language, it is clear that a party wishing to use statements in the written description to confine or otherwise affect a patent's scope must, at the very least, point to a term or terms in the claim with which to draw in those statements." *Johnson Worldwide Assocs. v. Zebco Corp.*, 175 F.3d 985, 989, 50 USPQ2d 1607, 1610 (Fed. Cir. 1999).

[8] See also *Vitronics Corp. v. Conceptronic, Inc.*, 90 F.3d 1576, 1582, 39 USPQ2d 1573, 1576 (Fed. Cir. 1996), ("[A] patentee may choose to be his own lexicographer and use terms in a manner other than their ordinary meaning, *as long as* the special definition of the term is *clearly stated* in the patent specification or file history. [Emphasis added.]"); *Multiform Desiccants Inc. v. Medzam Ltd.*, 133 F.3d 1473, 1477, 45 USPQ2d 1429, 1432 (Fed. Cir. 1998) ("Such special meaning, however, must be sufficiently clear in the specification that any departure from common usage would be so understood by a person of experience in the field of the invention."). See also MPEP §2111.02, subsection titled "Applicant May Be Own Lexicographer" and MPEP §2173.05(a) titled "New Terminology."

Failure by Applicant(s) in their next response to address this issue or to be non-responsive to this issue entirely will be considered a desire by Applicant(s) to forgo lexicography in this application and to continue having the claims interpreted with their ordinary and accustom meaning and with their broadest reasonable interpretation. Additionally, it is the Examiner's position that above requirements are reasonable.[9] Applicant(s) are also cautioned that even though claim interpretation begins with this presumption, after issuance the prosecution history may further limit claim scope if Applicant(s) disclaim or disavow a particular interpretation of the claims during prosecution. *Abbott Laboratories v. TorPharm Inc.*, 300 F.3d 1367, 1372, 63 USPQ2d 1929, 1931 (Fed. Cir. 2002). Unless expressly noted otherwise by the Examiner, the preceding claim interpretation principles apply to all examined claims currently pending.

Claim Rejections - 35 USC § 101

35 U.S.C. 101 reads as follows:

> Whoever invents or discovers any new and useful process, machine, manufacture, or composition of matter, or any new and useful improvement thereof, may obtain a patent therefor, subject to the conditions and requires of this title.

1. Claims 1-6, 8-15 and 17-21 are rejected under 35 U.S.C. 101 because the claimed invention is directed to non-statutory subject matter.

The basis of this rejection is set forth in a two-prong test of:

(1) whether the invention is within the technological arts; and

(2) whether the invention produces a useful, concrete, and tangible result.

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[9] The requirements are reasonable on at least two separate and independent grounds: first, the Examiner's requirements are simply an express request for clarification of how Applicant(s) intend their claims to be interpreted. Second, the requirements are reasonable in view of the USPTO's goals of compact prosecution, productivity with

For a claimed invention to be statutory, the claimed invention must be within the technological arts. Mere ideas in the abstract (i.e., abstract idea, law of nature, natural phenomena) that do not apply, involve, use, or advance the technological arts fail to promote the "progress of science and the useful arts" (i.e., the physical sciences as opposed to social sciences, for example) and therefore are found to be non-statutory subject matter. For a process claim, the recited process must somehow apply, involve, use, or advance the technological arts.

In the present case, there is no recitation or indication that the technological arts are involved in the method.

Specifically, claims 1-6, 8-15 and 17-21 only recite an abstract idea. The recited steps of merely paying fees, medical or otherwise in a system comprising service providers/doctors, service receivers/patients and a clearinghouse wherein the service providers subscribe to provide services (a predetermined type of service) to the service receivers, the service receivers subscribe with the clearinghouse to receive services from the service providers, the service receivers select a specific service provider who has subscribed to the clearinghouse to acts as a primary service provider (if not primary service receiver pays a fee and provider receives another fee from the clearinghouse, if provider not a subscriber then receiver liable for entire fee) for the service receiver, the clearinghouse collects plan fees (for a set period of time) from the service receivers on a set periodical basis and distributes at least a portion of the plan fees (for a set period of time) to the selected service providers on a set periodical basis as payment fees, and the service receivers receive services (pay a co-payment fee) from the selected service providers; in combination with an insurance coverage product; services provided in greater quantity then

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particular emphasis on reductions in both pendency and cycle time, and other goals as outlined in the USPTO's The

receiver liable for all or a reduced portion of the providers' fee. These steps only constitute an idea of how to effectuate payment of service fees

Additionally, for a claimed invention to be statutory, the claimed invention must produce a useful, concrete, and tangible result. In the present case, the claimed invention provides for payment of fees for services provided (i.e., repeatable, useful and tangible).

Although the recited process produces a useful, concrete and tangible result, since the claimed invention, as a whole, is not within the technological arts as explained above, claim 1-6, 8-15 and 17-21 are deemed to be directed to non-statutory subject matter.

2. Claims 1-6, 8-15 and 17-21 are rejected under 35 U.S.C. 101 because the claimed invention is directed to non-statutory subject matter. The claims are directed to or include within its scope a human being and thus is not considered to be patentable subject matter under 35 U.S.C. 101. See In re Wakefield, 422 F.2d 897, 164 U.S.P.Q. 636 (CCPA 1970). The claims recite "service providers/doctors and service receivers/patients".

Claim Rejections - 35 USC § 102

The following is a quotation of the appropriate paragraphs of 35 U.S.C. 102 that form the basis for the rejections under this section made in this Office action:

> A person shall be entitled to a patent unless –
>
> (b) the invention was patented or described in a printed publication in this or a foreign country or in public use or on sale in this country, more than one year prior to the date of application for patent in the United States.

1. Claims 1-6, 8-15 and 17-21 are rejected under 35 U.S.C. 102(b) as being anticipated by Jena L. Kennedy, Intro to Managed Care – Fundamentals of Managed Care Coverage and

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21st Century Strategic Plan, June 3, 2002 available at www.uspto.gov/web/offices/com/strat2001/index.htm.

Providers, May 1998, pp. iii-ix, 2-4, 19, 28-33, 35-37, 40-44, 46-49, 52-55, 58-63, 66-73, 78-86, 90-93.

As to claims 1, 13 and 18, Kennedy teaches a system for the payment of [medical] fees (Health Maintenance Organizations pp. 40-44 and 46-49, Preferred Provider Organizations pp. 52-54, Exclusive Provider Organizations pg. 54) comprising:

a. service providers/doctors (Managed Care Concepts pp 28-29, Health Maintenance Organizations pp. 40-44 and 46-49, Preferred Provider Organizations pp. 52-54, Exclusive Provider Organizations pg. 54);

b. service receivers/patients (Managed Care Concepts pp. 28-29, Health Maintenance Organizations pp. 40-44 and 46-49, Preferred Provider Organizations pp. 52-54, Exclusive Provider Organizations pg. 54); and

c. a clearinghouse (Managed Care Concepts pg. 28 – managed care organization, Health Maintenance Organizations pp. 40-44 and 46-49, Preferred Provider Organizations pp. 52-54, Exclusive Provider Organizations pg. 54, Funding Aspects of Health Care Coverage pp. 78-86),

wherein, the service providers/doctors subscribe with the clearinghouse to provide [a predetermined quantity of medical] services to the service receivers/patients receivers (Managed Care Concepts pg. 28 – managed care organization, Health Maintenance Organizations pp. 40-44 and 46-49, Preferred Provider Organizations pp. 52-54, Exclusive Provider Organizations pg. 54, Funding Aspects of Health Care Coverage pp. 78-86; pg. 29 – primary care physicians have often been called gatekeepers, i.e. coordinate and manage all aspects of a members care, pg. 67 –

Member Services – benefits and coverage options[10]; pg. 90 – Figure 8-2 Benefits That Federally Qualified HMOs Are Required to Provide; pg. 19 - Exclusions – have been included into HMOs see footnote 12.), the service receivers/patients subscribe with the clearinghouse to receive [medical] services from the service providers/doctors (Managed Care Concepts pp. 28-29, Health Maintenance Organizations pp. 40-44 and 46-49, Preferred Provider Organizations pp. 52-54, Exclusive Provider Organizations pg. 54), the service receivers/patients select a specific service provider/doctor who has subscribed to the clearinghouse to act as a primary service provider/doctor for the service receiver/patients, the clearinghouse collects plan fees from the service receivers/patients on a set periodical basis (for a set period of time) [11] and distributes at least a portion of the plan fees to the selected service providers/primary doctors on a set periodical basis (for a set period of time) [12] as payment fees (Managed Care Concepts pg. 28 – managed care organization, Health Maintenance Organizations pp. 40-44 and 46-49, Preferred

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[10] Benefits and coverage options inherently cover exclusions and limitations on coverage. These have followed through into HMOs. See, e.g. Jon B. Christianson, et al., Strategies for Managing Service Delivery in HMOs: An Application to Mental Health Care, Medical Care Research and Review, Vol. 54, no. 2, June 1997, pp. 200-222, esp. 206. Mental health care specifically excluded or some mental health problems or treatment specifically excluded from some benefit packages. Others limited/restricted the amount of services that HMO mental health care providers agree to deliver, then require either special authorization to continue service delivery. Ninety percent of HMOs limit the number of hospital days and number of outpatient visits that they are obligated to deliver as medically necessary during a given benefit period. See also T. Allen Merritt, MD, et al., Clinical Practice Guideline in Pediatric and newborn medicine: Implications for Their Use in Practice, Pediatrics, Vol. 99, No. 1, January 1997, pp. 100-114 and Thomas S. Bodenheimer and, MD, MPH and Kevin Grumbach, MD, Capitation or Decapitation Keeping Your Head in Changing Times, JAMA, Vol. 276, No. 13, October 2, 1996, pp. 1025-1031.

[11] As set period of time is not specifically defined in the specification, the examiner is interpreting set period of time in this instance to mean "payment of a pre-determined amount by the consumer each time period to a central clearing house for the plan" or to "allow the consumer to have set payments per time period." See Specification at page 3, lines 27-28 and pg. 4, lines 11-12. In other words, the service receiver/patients enters into a subscription to the plan. A subscription is defined as an arrangement for providing, receiving, or making use of something of a continuing or periodic nature on a prepayment plan. See Merriam Webster's Collegiate Dictionary, Tenth Edition,1996, definition 3, pg. 1173.

[12] The examiner is interpreting set period of time to mean a predetermined period of time or within an agreed upon period of time as set forth on page 6, lines18 and 22-23 of the Specification. The Specification specifically states that "fees by patients to clearinghouse in exchange for the ability to obtain a certain type and quantity of services from doctors per predetermined time period" and "Patients will pay clearinghouse a monthly services fee to obtain a set of services from this primary care doctors, ... within an agreed upon time period.

Provider Organizations pp. 52-54, Exclusive Provider Organizations pg. 54, Funding Aspects of Health Care Coverage pp. 78-86; pp. 41-42 – Prepaid care subscribing to a plan; pp. 89-90 - COBRA and OBRA; plan fees are collected periodically and even for a set period of time, this set period of time if employed determined by the employee and can last for one period or any length of the employment period or up to the end of the COBRA coverage as mandated by law; pg. 72 – Provider relations – negotiating and entering into contracts with providers. Contracts are for a set period of time and are then renegotiated. Pg. 48 – the medical group negotiates annually with Kaiser … we negotiate that the capitation payment each year …), and the service receivers/patients receive [medical] services from the selected service providers/primary doctors (Managed Care Concepts pp 28-29, Health Maintenance Organizations pp. 40-44 and 46-49, Preferred Provider Organizations pp. 52-54, Exclusive Provider Organizations pg. 54).

As to claims 2 and 14, Kennedy teaches plan fees are collected for a set period of time[13] (pp. 41-42 – Prepaid care subscribing to a plan; pp. 89-90 - COBRA and OBRA; plan fees are collected periodically and even for a set period of time, this set period of time if employed determined by the employee and can last for one period or any length of the employment period or up to the end of the COBRA coverage as mandated by law).

As to claims 3 and 15, Kennedy teaches the clearinghouse distributes the payment fees to the selected service provider/primary doctor for a set period of time[14] (pg. 72 – Provider relations

[13] As set period of time is not specifically defined in the specification, the examiner is interpreting set period of time in this instance to mean "payment of a pre-determined amount by the consumer each time period to a central clearing house for the plan" or to "allow the consumer to have set payments per time period." See Specification at page 3, lines 27-28 and pg. 4, lines 11-12. In other words, the service receiver/patients enters into a subscription to the plan. A subscription is defined as an arrangement for providing, receiving, or making use of something of a continuing or periodic nature on a prepayment plan. See Merriam Webster's Collegiate Dictionary, Tenth Edition,1996, definition 3, pg. 1173.

[14] The examiner is interpreting set period of time to mean a predetermined period of time or within an agreed upon period of time as set forth on page 6, lines18 and 22-23 of the Specification. The Specification specifically states

– negotiating and entering into contracts with providers. Contracts are for a set period of time and are then renegotiated. Pg. 48 – the medical group negotiates annually with Kaiser ... we negotiate that the capitation payment each year ...).

As to claim 4 and 19, Kennedy teaches the selected service providers provide a predetermined type of service to the service receivers (pg. 28 – the primary care physician is usually a general practitioner, family practitioner or obstetrician/gynecologist).

As to claims 5 and 20, Kennedy teaches the selected service providers provide a predetermined quantity of services to the service receivers (pg. 29 – primary care physicians have often been called gatekeepers, i.e. coordinate and manage all aspects of a members care, pg. 67 – Member Services – benefits and coverage options[15]; pg. 90 – Figure 8-2 Benefits That Federally Qualified HMOs Are Required to Provide; pg. 19 - Exclusions – have been included into HMOs see footnote 12.).

As to claims 6, 17 and 21 Kennedy teaches the service receivers pay a co-payment fee to the selected service provides when the service receivers receive the services from the selected services providers (pg. 41 – Prepaid care)

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that "fees by patients to clearinghouse in exchange for the ability to obtain a certain type and quantity of services from doctors per predetermined time period" and "Patients will pay clearinghouse a monthly services fee to obtain a set of services from this primary care doctors, ... within an agreed upon time period.

[15] Benefits and coverage options inherently cover exclusions and limitations on coverage. These have followed through into HMOs. See, e.g. Jon B. Christianson, et al., Strategies for Managing Service Delivery in HMOs: An Application to Mental Health Care, Medical Care Research and Review, Vol. 54, no. 2, June 1997, pp. 200-222, esp. 206. Mental health care specifically excluded or some mental health problems or treatment specifically excluded from some benefit packages. Others limited/restricted the amount of services that HMO mental health care providers agree to deliver, then require either special authorization to continue service delivery. Ninety percent of HMOs limit the number of hospital days and number of outpatient visits that they are obligated to deliver as medically necessary during a given benefit period. See also T. Allen Merritt, MD, et al., Clinical Practice Guideline in Pediatric and newborn medicine: Implications for Their Use in Practice, Pediatrics, Vol. 99, No. 1, January 1997, pp. 100-114 and Thomas S. Bodenheimer and, MD, MPH and Kevin Grumbach, MD, Capitation or Decapitation Keeping Your Head in Changing Times, JAMA, Vol. 276, No. 13, October 2, 1996, pp. 1025-1031.

As to claims 8, Kennedy teaches that if the service receiver is provided services from a services provider who has subscribed to the clearinghouse but who has not been designated as the primary service provider for the service receiver, the service receiver pays to the non-primary service provider a service fee and the non-primary service provider receives a fee from the clearinghouse (pp. 41-42).

As to claims 9, Kennedy teaches that if the service receiver receives services from a service provider that is not subscribed to the clearinghouse no fee is paid to the service provider by the clearinghouse and the service receiver is liable for the service provider's entire fee (pg. 41 – Networked providers and negotiated fees).

As per claims 10 and 11, Kennedy teaches that if the service receiver receives services from the selected service provider in a quantity greater than the predetermined quantity, either no fee is paid to the selected service provider by the clearinghouse for any services over the predetermined quantity and the service receiver is liable for the selected service providers' entire fee or no fee is paid to the selected service provider by the clearing house for any services over the predetermined quantity and the service receiver is liable for the selected service providers' fee at a reduced rate (pp. 52-54 – Preferred Provider Organizations – utilize primary care physicians, it is inherent/implicit because by law in certain states participating/preferred physicians can collect the difference between the Plan's payment, i.e. a reduced fee and the physician's charge and if you choose an out of plan primary care physician you would pay the full difference – see Blue Cross and Blue Shield Service Benefit Plan 1998).

As per claim 12, Kennedy teaches claim 1 in combination with an insurance coverage product (pp. 88-89 – flexible benefits plan/cafeteria plan – can include health insurance, life insurance, legal benefits, disability benefits and medical care benefits).

Conclusion

Any inquiry concerning this communication or earlier communications from the examiner should be directed to Jennifer I. Harle whose telephone number is (703) 306-2906. The examiner can normally be reached on Monday - Thursday.

If attempts to reach the examiner by telephone are unsuccessful, the examiner's supervisor, Richard Chilcot can be reached on (703) 305-4716. The fax phone numbers for the organization where this application or proceeding is assigned are (703) 305-7687 for regular communications and (703) 305-7687 for After Final communications.

Any inquiry of a general nature or relating to the status of this application or proceeding should be directed to the receptionist whose telephone number is (703) 308-1113.

Jennifer Ione Harle
February 5, 2003

Richard Chilcot
Supervisory Patent Examiner
Technology Center 2800
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